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CLINICAL LECTURE.

ABDOMINAL SECTION FOR THE REMOVAL OF AN OVARY.—OPERATION FOR PYOSALPINX.—OPERATION FOR PYOSALPINX WITH EXTENSIVE PERITONITIS.—VESICO-VAGINAL AND RECTO-VAGINAL FISTULÆ.¹

BY E. E. MONTGOMERY, M. D.,

PROFESSOR OF GYNECOLOGY, MEDICO-CHIRURGICAL COLLEGE; OBSTETRICIAN TO THE PHILADELPHIA HOSPITAL.

Removal of Ovary.

Gentlemen: The first patient I bring before you this morning is a woman twenty-one years old. Two years and a half ago one ovary was removed; but in two months she suffered as severe distress on the other side, and came here to have that organ removed also. The examination by the attending gynecologist, however, led to the belief that the condition was simulated on the part of the patient, with the desire to have the organ removed for immoral purposes. In order to satisfy the patient and make a mental impression, an incision was subsequently made through the abdominal muscles, and the wound was sewed up. This did not result in the beneficial results desired, and the patient continued to suffer. She again returned to the house, and was found in the ward upon my entrance upon duty. Her claim of severe pain has been confirmed by her mistress, with whom she has lived for a length of time, who assures us that so far as she can judge the woman has continuously suffered. The doubt in

this matter has been due to the fact that a physical examination disclosed no enlargement of either ovary or tube. In fact the ovary is situated so high that it is not readily brought under observation by palpation.

Two weeks ago I opened the abdomen and found upon the right side a cystic ovary, three times the normal size, which I removed. The woman now expresses herself as being greatly relieved and feeling better than she has at any time since the last operation. The course of her convalescence has been uninterrupted; her highest temperature has been 101°, which occurred on the eleventh day, and soon became normal and has continued so since. She has had no anodyne since the operation. As a rule no anodyne is given unless the patient is exceedingly restless, as morphine or opium decrease the secretions, lessen the powers of elimination and so enhance the chance of septicemia. In every abdominal operation the injured peritoneum throws out a serous secretion, which in normal conditions is reabsorbed. If the secretions, however, have been interrupted, this is not so readily taken up, and affords an opportunity for the multiplication of any stray pathological germs which may have been left in the peritoneal cavity. If an ovaritis comes from gonorrhœa, remove both ovaries and tubes, even though but one seems to be affected; because the other organ if not actively diseased will later be the source of serious trouble. In the patient upon whom I have operated, it is quite probable that she had suffered distress from this organ, but that in the greater distress felt from the other, the symptoms from this one had been overshadowed, and only disclosed their character when the other had been removed. The experience of all operators demonstrates that when the disease exists sufficiently to justify the removal of one ovary the other should accompany it.

¹ Delivered at the Philadelphia Hospital.

Removal of Appendages for Pyosalpinx.

This woman is twenty-four years old. She has suffered for several months with pain in the pelvis. Upon examination a mass was found posterior to the uterus, which was recognized as the enlarged and adherent uterine appendages resulting from a pyosalpingitis, and two weeks ago the abdomen was opened and the left ovary and tube were removed. These were not found to be in the condition which was expected, although they were considerably inflamed. Examination of the opposite appendages, however, showed the tube to be curved around Douglas's pouch and firmly adherent to the peritoneal surfaces, with the ovary lying upon the opposite side. As this was enucleated and raised up, both ovary and tube were found to be filled with pus. The pus sac burst in its removal, permitting its contents to escape into the cavity; this was, however, flushed out immediately and a drainage-tube was inserted. The temperature within the next two days went up to 102° , and on the fifth day it had reached 103° ; after which it gradually declined, and has now been normal for some days. As we feared that the contents of this sac were virulent, we immediately flushed out the abdominal cavity with hot water, and followed this with frequent irrigations with a sulphurous acid solution—an agent which is an excellent germicide and is less irritating than carbolic acid or bichloride solution. At this time there is still some evidence of irritation in the left groin, as is shown by pains down the front of the thigh, and more especially in the knee. This will have to be watched with care, as there is a strong tendency to phlebitis. A glass drainage-tube was removed at the end of a week and replaced by a rubber one, and the latter was gradually shortened until the whole of it has been removed, and the opening is now entirely closed. In a case in which there has been pus, do not be in too great a hurry to remove the drainage-tube, as the pus may collect in the lower part of the abdomen. The inflammation that occurs following the operation or about the pedicle after the infection of the silk generally used for its ligation, may keep up an irritation and cause a pus-secreting fistulous track and remain for some length of time—indeed until the ligature sloughs off and is discharged. For this reason the drainage-tube should be

gradually removed, permitting the deeper part to close before the opening in the integument has done so. On account of the danger from the silk ligatures, I have in late operations been using the prepared chromicized catgut ligatures, and have found them much less likely to give rise to any subsequent irritation.

Operation for Pyosalpinx with Extensive Peritonitis.

This colored woman has been in the hospital for some time. She says her health was good up to six weeks ago, and since then she has experienced a great amount of pelvic distress, but from the inflammatory mass and adhesions that were found, I think her trouble must have been in existence a much longer time. This mass extended above the brim of the pelvis and held the uterus immovable. The pelvic contents felt as if they had been immersed in melted glue, which had subsequently become hard. There had evidently been a peritonitis. This affection was formerly called peri-metritis when confined to the pelvis, and the accompanying inflammation of the cellular tissue was called a para-metritis. Both of these names are unfortunate, as they do not explain the real origin of the trouble, which arises neither in the cellular tissue nor in the peritoneum, but in the tube and ovary. The inflammation of the cellular and peritoneal tissues is similar to that which takes place in the cellular tissue about the eye in a case of conjunctivitis. This inflammation of the tube and ovary may have been primarily local; I mean it may have originated as the result of cold or exposure during the congestion of these organs which takes place at or near the menstruation, or it may have come from a salpingitis, which was secondary to endometritis or vaginitis. If the latter, it has been most probably of specific origin. When this abdominal cavity was first opened it was impossible to determine the relation of anything within it. The pelvic cavity was filled up with a mass of exudation, gluing everything together and completely obscuring landmarks. The finger was pushed into the mass at a point where we would expect to find the uterus, the fundus of this organ was found and the tissue enucleated from it on either side. Tracing out to the left side, a large pus sac was found situated deep down in Douglas's pouch, closely adherent to the anterior wall of the rectum. Its walls were very thin and

was torn into in the effort to remove it. The sac could be barely reached with the ends of the fingers, and considering its close adhesion to the rectum, it was decided not to attempt its entire removal. A drainage-tube was inserted, placing its end in this sac. The oozing surfaces which had been torn up were mopped with a sponge wet with 1 to 4 parts of Monsel's solution. The abdominal cavity was thoroughly irrigated with quite hot water, and the abdominal wound was closed. The abdominal cavity was subsequently irrigated with a saturated solution of boro-glyceride every three hours, allowing as much of the solution to remain in the cavity as it would hold. In this way the peritoneal surfaces were kept pure by the presence of a disinfectant solution, and the probability of unfortunate adhesions was decreased.

I have shown you to-day, gentlemen, three patients of different conditions, in all of whom the operation was absolutely indicated. These cases were all operated upon on the same day, requiring two hours for the three operations. The last case is one which impresses upon us the amount of manipulation the peritoneal cavity can be subjected to without danger to the patient. The convalescence of this woman has been uninterrupted. Her temperature at no time exceeded 100°, and she has suffered less distress and discomfort since the operation was performed than she did during the weeks previously. This is a case in which I would have formerly closed up the wound without having attempted to interfere; yet experience discloses that these are the very cases which derive the most benefit from operative interference. Now in the after-treatment of patients it is important to endeavor to prevent unfortunate results from secondary inflammation and adhesions. You will ask how this can best be accomplished. Where extensive adhesions have been torn up, or there has been much pus, a drainage-tube should be used and the cavity should be frequently irrigated with a disinfectant solution. The solutions of carbolic acid and bichloride are likely to produce an irritation of the delicate epithelium of the peritoneum, leading to increased adhesion. The best disinfectant for this purpose is a solution of boro-glyceride, which serves as a disinfectant, is not irritating—as the glycerine has an affinity for the watery portions of the blood—increases the amount of transudation from the blood-vessels, thus unload-

ing them, and by its presence in the cavity prevents adhesions. The cavity may be kept filled with the solution if necessary for two or three weeks. The rapid recovery of the patient from such an operation demonstrates clearly that the tube and ovary are the offending tissues, and that in the inflammatory condition, the pelvic cellular tissue and peritoneum are secondary.

The thought I wish to leave with you is, that these inflammatory conditions arise from the disease of the tubes and ovaries, and that consequently the terms peri- and parametritis are misnomers, and that the correct pathology is better indicated by the term salpingo-ovaritis.

Vesico-vaginal and Recto-vaginal Fistulæ.

I expected to have shown you to-day a patient suffering with both vesico- and recto-vaginal fistula, but she unfortunately left the house yesterday. In the absence of the patient I will use these diagrams explaining such conditions. First I will say to you that the recto-vaginal fistula is one which communicates with the rectum and through which the contents of that viscus pass into the vagina. Where this form of fistula is present you should always carefully examine the rectum to determine whether any stricture is present. In the case I would have shown you, such an examination revealed a stricture, resulting from malignant disease of the rectum. In such a case you can readily recognize that no operation would afford any probability of relief, and an attempt to close the fistula would be absolutely contra-indicated unless it had been preceded by an operation upon the intestine, known as colotomy. The fistulæ of the anterior wall of the vagina are vesico-vaginal, urethro-vaginal and vesico-uterine. These terms are self-explanatory. These fistulæ are usually the result of injuries during parturition. The head of the child rests in the vaginal canal for a length of time, pressing upon its walls until their vitality has become destroyed. The fistula may not be apparent at first, but results some days later when the slough has separated. These fistulæ may be very small or quite extensive, involving the greater part of the vesico-vaginal septum. The fistula is usually very readily determined. In some forms of fistula we may have a continuous discharge of urine from the vagina and regular discharges from the bladder. This may rise from either

one of two conditions. The fistula may be so situated that only the flow passes into the vagina, the remainder is discharged into the urethra; or the vaginal wall may have sloughed in such a position as to open the ureter, from which the urine empties into the vagina, the other ureter continues to empty into the bladder. When a vesicovaginal fistula is of very small diameter and cannot readily be discovered by inspection of the vaginal walls, it may be more readily determined by injecting the bladder with some colored liquid, such as milk or cochineal, and observing the point from which it makes its exit into the vagina. Where there is a continuous flow of urine into the vagina, or when such an injection is made into the bladder, it is found that the urine discharged into the vagina still remains uncolored, it is evident that we have to deal with a fistula of the ureter and not of the bladder. The condition of the patient with the parts continuously bathed with urine, is one of exceeding discomfort. The salts of the urine are deposited upon the external parts, giving rise to irritation of the skin, and an eczematous eruption greatly adding to her distress. Preparatory to an operation all cicatricial bands should be cut and tampons should be worn that will so stretch adhesions and the vaginal walls that the surfaces may be brought together without undue tension upon the sutures. This should be done some time before the operation. In performing the operation the patient should be placed in the lithotomy position or in either Sims' position or that of Bozeman. If the fistula be small and well down, the latter position will be the preferable one. In flushing the surfaces it should be done in such a way as not to injure the mucous membrane of the bladder, and the sutures should be introduced to the edge of the vesical mucous membrane without entering it. The introduction of the sutures through the vesical mucous membrane is likely to result in a fistula. The sutures should extend well out upon the angles of the wound on each side. The material for sutures may be either silver wire, silk-worm gut or thread. The first two are generally preferred. After the wound has closed the catheter should be frequently used. The catheter should be thoroughly disinfected and the same cautions should be exercised with regard to the vestibule and orifice of the urethra, lest some extraneous material should be carried into the urethra and bladder, giving rise to urethritis or cystitis, which may greatly complicate the convalescence of the patient. No vaginal injections should be used within forty-eight hours, lest the plastic exudation be washed off, decreasing the probability of a successful result. After this time disinfectant injections may be used. In cases in which the ureter is the seat of fistula, it may be reached by passing the Pawliks catheter through the urethra and an opening into the bladder, thus reaching the orifice of the ureter, then an incision may be made on each side of this and the edges may be freshened and the sutures introduced in such a way as to turn the orifice back into the bladder.

COMMUNICATIONS.

THE PROPRIETY OF OVARIOTOMY.

BY J. H. KELLOGG, M. D.,

BATTLE CREEK, MICH.

I do not propose to undertake an exhaustive discussion of this question, my chief purpose being to combat the sentimental notions which exist among the laity, and to some extent even among the profession, against this operation. Among the laity there is a general prejudice against the performance of an operation for the removal of the ovaries, unless the patient has reached a point at which life is in so great peril that death is inevitable without an operation. One of the causes of this prejudice is undoubtedly the great fatality which has, until recent times, attended this operation, and it must be admitted that there is still room for dread of the operation, as one not infrequently sees statistics of operators which indicate a mortality of from fifty to seventy-five per cent., and a fatality even higher still has sometimes been recorded. But this prejudice will certainly give way when the public becomes aware of the fact that by the skilful employment of methods representing the most recent advances made in abdominal surgery by Tait, Keith, Bantock and others of the great ovariologists, the proper preparation of the patient before the operation, and skilful nursing afterwards, the mortality may be reduced to so low a point

¹ Part of a paper read before the Twenty fifth Annual Meeting of the Michigan State Medical Society, 1890.

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as three or four per cent. Indeed, one may say that, leaving out of consideration those desperate cases which, before operation, must be regarded as almost or altogether hopeless, the average mortality of ovariectomy may be fairly considered as not greater than two or three per cent. in the hands of competent operators. But so long as this operation is undertaken by incompetent surgeons, who depend upon the operation as an advertisement, whether the patient recovers or succumbs—if the patient dies, of course, it is the fault of the patient, and not of the operator—this operation will not be regarded by those who might be benefited by it, with that favor of which it is really deserving.

Ovariectomy may be justly said to be, when it has a fair chance, the safest of all capital operations, although undoubtedly demanding the highest degree of skill and judgment in its performance, and the best conditions possible to command. The surgeon who opens the abdominal cavity must be prepared to do anything from the removal of a simple cyst, the simplest of all abdominal operations, to the removal of the spleen, a kidney, or the entire uterus and its appendages, or even the splicing of an intestine. It is never possible to know absolutely in advance what one may encounter when opening the abdominal cavity; and in many cases the leaving of an operation incomplete is equivalent to signing the patient's death-warrant. There are no operations in surgery more trying to the surgeon's fortitude, patience and skill, and indeed not infrequently to his physical endurance, than an operation for diseased and adherent appendages such as are found in a large proportion of this class of cases. Often the ovaries and tubes are so matted together, and so completely incorporated with the tissues of the uterus, intestines, bladder and abdominal walls, that it seems impossible to locate them, much less to separate them from the structure to which the inflammatory action has attached them. It is in many of these cases necessary to actually dig and tear the diseased structures from the mass of inflammatory exudate in which they are embedded, an operation which requires no small degree of care and dexterity to avoid making a rent in the rectum or colon, or tearing into some other viscus. In spite of every possible precaution this accident may sometimes occur, and then the surgeon must be prepared to repair the damage he has done, in a rapid and efficient manner.

The time will undoubtedly come in this country, as is already the case in England, when public sentiment as well as the average professional conscience, will have developed to such a degree that no physician will be allowed to undertake abdominal surgery who has not made a careful special preparation for this particular line of surgical work, and who is not prepared to give to his patients the benefit of not only the best methods of operation and a high degree of manual dexterity, but the proper conditions for after care, which are as essential as the skilful performance of the operation. It must of course be admitted that emergencies may occur in which the abdomen must be opened at once, and in which the delay occasioned by bringing a specialist to the patient, or the patient to a specialist, would be more hazardous than the undertaking of the operation under whatever disadvantageous circumstances may surround the patient. Under these circumstances, the surgeon must, of course, do his best, although in many instances, the unaided efforts of nature will give the patient a better chance for life than efficient or bungling surgery.

Another cause of the popular prejudice against ovariectomy, and which is possibly still shared to some extent by the profession, is the incorrect notion that by the removal of the ovaries a woman is unsexed, that she loses her natural womanly attributes, and becomes masculine. The careful inquiries of Tait and other ovariectomists have thoroughly demonstrated the fallacy of this erroneous notion. It was known even to the ancients that the removal of the ovaries in a female, or the testicles in a male, was practically without effect upon a mature individual, except to render motherhood or fatherhood impossible. The sexual sense and the ability for sexual cohabitation remain unimpaired, or may even be increased by removal of the ovaries as in cases of dyspareunia. Mr. Tait stated to me with very great emphasis, that removal of the ovaries does not in the slightest degree unsex a woman, and that in numerous instances there had been reported to him a marked increase in the sexual appetite, rather than a loss in this particular.

It is apparent, then, that if a function so entirely dependent upon the sexual organs is not in the slightest degree impaired by this operation, it cannot possibly exert any pernicious influence upon the general system. If the operation is performed upon

an undeveloped individual, that is, a person who has scarcely attained the age of puberty and in whom the sexual functions are not yet fully established, the case is different, although among some Eastern nations with whom the practice of making eunuchs at one time prevailed, the operation was not infrequently carried to the extent of amputation of the external organs, as it was found that a simple removal of the testicles did not produce complete sexual disability. I was consulted some time since on account of a nervous affection, by a man of thirty years, whose testicles were removed some five years previous. He is a married man and informed me that no symptoms of sexual incompetency had appeared.

The purpose of removal of the ovaries in other cases than those of morbid growths of the organs may be either to get rid of diseased ovaries or tubes, which have become the seat of constantly recurring inflammations, or to bring about prematurely the change of life by stopping menstruation, and thus to secure the cessation of the growth, or the disappearance of atrophy, or of a fibroid tumor of the uterus. That the removal of the ovaries and tubes will accomplish these results, has been abundantly proved by the experience of Hegar, Tait and numerous other operators, and I might present, in addition, cases in my own practice, since the performance of which ample time has elapsed to leave no possible doubt of the permanence of the results; as, for example, the case of a young woman sent to the Sanitarium by Dr. French, of Ypsilanti. The operation was performed nearly five years ago, the occasion for it being a large fibroid growth of the uterus, which gave rise to almost constant hemorrhage. The hemorrhage, together with continued vomiting, had reduced the patient to a state of inanition which rendered death probable within a few weeks if some relief was not afforded. Within six weeks after the operation the tumor had diminished to about one-half its former size, the hemorrhage had ceased, the patient was relieved of pain and nausea and was gaining rapidly in flesh. More than a year ago I received a letter from her making application for a position as an employé in the hospital, the patient saying she was enjoying very comfortable health.

There are, undoubtedly, thousands of women leading lives of continued invalidism and great suffering who should be afforded relief by this operation. The woman

who is carrying about in her pelvis a Fallopian tube filled with pus, or whose ovaries and tubes have been damaged by a salpingitis of gonorrheal or puerperal origin, is in constant danger of death through the rupture of a distended tube and resulting peritonitis, incurring at every menstrual period the risk of a renewal of the inflammatory action—and should she become pregnant—the risk of almost certain death from puerperal fever. Not understanding her condition, she goes about from one specialist to another, is treated by pledgets, pessaries, powders and every sort of internal and external application, without other relief than simple palliation. In many instances the suffering at the menstrual period is so great that the morphia habit is acquired, or the habit of using alcoholic stimulants to the extent of inebriety. A number of cases belonging to each of these classes have come under my professional care. In many instances the patient's medical adviser is not himself aware of the actual state of things, and treats his patient for neuralgia, chronic peritonitis, malaria and a variety of other maladies, either in conjunction or succession, never once suspecting the real nature of the difficulty. Several patients upon whom I have operated have gone through exactly this experience. The gratitude expressed by them on being rescued from a state of constant misery and uselessness, is certainly an ample justification of the operation and no small compensation to the surgeon for his efforts. Recently a patient upon whom I had some months ago performed ovariectomy for the relief of chronic salpingitis and frequently recurring hematocele of the right ovary, said to me that she could not be induced to return to her old condition for a fortune. Life was then worth nothing to her. Now she has before her the prospect of a happy and useful life, uninterrupted by continually recurring painful and dangerous illnesses. Why should such a patient be encouraged to continue under hopeless and often worse than useless measure of treatment? A patient whose condition is such as to demand the removal of the uterine appendages is usually in a sterile condition through occlusion of the tubes. In married women there is very frequently a history which indicates the occurrence of a salpingitis following an ordinary confinement or a miscarriage some years previous and no pregnancy since. It is something more than simply an error—it

seems to encourage prolonged years after that there be chances. these cases for an impulses therapeutic may be n galvanism tain num short of a tion of t relief.

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seems to me to be absolutely criminal—to encourage such patients to continue under prolonged treatment, month after month, and year after year, entertaining the vain hope that they may again become pregnant, and thus be cured of their maladies by pregnancies. I have had more than a score of these cases in which women were longing for an impossible pregnancy, not from the impulses of motherhood, but seeking it as a therapeutic measure. Many of these cases may be made comfortable by rest in bed, galvanism and other measures; but a certain number will remain, to whom nothing short of an operation for complete extirpation of the diseased structures will bring relief.

Tait and others have called attention to the fact that pyosalpinx, and similar conditions of the appendages, are not infrequently the cause of fatal puerperal fevers. The pressure induced by confinement causes a rupture of the sac, and as a result a general and fatal peritonitis is set up. In six cases of death from puerperal fever, occurring in one of the English lying-in hospitals, the disease was found to be due in five instances to this one cause.

Not infrequently a chronic inflamed ovary is, by the local treatment applied, converted into a pyosalpinx or an abscess of the ovary. I have met several cases in which the patient's condition has been thus greatly aggravated by treatment. Dilatation of the cervix, division of the cervix, repair of a lacerated cervix, applications to the cavity of the uterus and even the placing of a pessary, have been sufficient in various cases to produce this result. It has indeed happened that the force employed in efforts to reduce a retroverted uterus has resulted in the rupture of a distended tube, leading to fatal peritonitis. In fact, in observing the thinness of the cyst wall, and the readiness with which rupture occurs in operation for the removal of the appendages in cases of this kind, I have been led to wonder that fatal accidents of this sort are not much more frequent than they are. Considering, also, that the fatality of pyosalpinx when left to itself, is fully twenty-five per cent., whereas good surgical methods may secure ninety-seven per cent. of recoveries, while in cases of cirrhosis of the ovary, chronic ovaritis and similar cases, the death-rate should not be more than one or two per cent. under the most favorable conditions, why should a woman be encouraged to con-

tinue in a state of chronic invalidism, a slave to invalid habits, continually dependent upon a doctor, often a prey to charlatans, and carrying about with her a source of incessant suffering and continual peril to life, which might be removed by an operation which involves far less risk to life than six months of living in the manner described? To speak of the removal of the appendages in a case of this sort as a mutilation, is as absurd as to apply such a term to the removal of a gangrenous limb or a cancerous breast. Cirrhotic ovaries in which the normal ovarian tissue is largely replaced by dense, contracting, fibrous tissue, are often the cause of constant and agonizing pain, which is curable only by removal of the diseased organs. Dr. Tait has called attention to the results of what he calls exanthematic inflammation of the ovaries, as a complication of scarlet fever, small-pox and other eruptive disorders. These conditions are often the cause of constantly recurring pelvic inflammations, sometimes at each menstrual period. Sometimes, also, we find in these conditions the true cause of an intractable sciatica, a spinal irritation, an incurable dyspepsia or a chronic neurasthenia which baffles the skill of the neurologist. There are few men who would not immediately insist upon the removal of diseased testicles which they know to be functionally useless. Why, then, should women be encouraged to nurse with such care, and to cling with such tenacity to ovaries long since capable of no other than dangerous and pernicious activity, and the removal of which may be accomplished so safely and with so certain a prospect of complete relief from maladies otherwise irremediable? These are questions, it seems to me, every intelligent physician should ask himself, when brought to deal with patients of the class referred to.

TREATMENT OF CHRONIC SUPPURATION OF THE MIDDLE EAR.

BY GEORGE CLEARY, M. D.,
DENVER, COL.

Dr. MacEwen, of Glasgow, has recently said that "a person suffering from a chronic suppuration from the ear was in a position of one with a charge of dynamite in the interior of the head, which might explode disastrously at any moment." The dangers to

life from this disease are cerebral abscess, meningitis, pyemia and hemorrhage. As to the first mentioned complication, it is now generally believed that a suppurative process in the ear is necessary for the production of an abscess of the brain. Fatal hemorrhage may occur from the internal carotid, because of caries of the canal in the petrous portion of the temporal bone through which the artery passes, also from destruction of the bony wall that separates the mastoid process from the lateral sinus, and again from the jugular vein by the breaking down of the thin plate of bone which forms the floor of the tympanum, separating the latter from the vein.

Having briefly stated the dangers to life from this disease, I wish to say a few words with reference to its effects upon the hearing. There is no affection of the middle ear in which the auditory apparatus is so jeopardized as it is in chronic otorrhoea. Not only the whole middle ear is involved, but also, in almost every case, the membrana tympani and very often the external auditory meatus, the labyrinth and the osseous walls of the middle ear. It is a common occurrence to find large rents in the drumhead which only too often remain permanently open or the entire membrane may be swept away, with loss at the same time of portions of the ossicles or the whole of them. With such dangers as these, it is easy to understand the amount of permanent defect of hearing likely to result. This will explain all the more clearly the reason why we should be solicitous about an acute suppuration, lest it becomes chronic. Chronic suppuration very often follows a neglected acute otitis, especially when the nutrition of the general organism is disturbed by other affections.

But the cases of acute suppuration which are most apt to become chronic are those which arise in the course of the acute exanthemata. The reason for this is the attention demanded by the greater malady, to the neglect of the apparently lesser one. I know I am at variance with many in this respect, but I can so far truthfully say that I cannot recall even a single case (where I had the management, in a reasonable time after the occurrence of the suppuration) which did not go on to complete recovery. I mean by this not only the arrest of the discharge, but the restoration of the hearing as well. When the disease has existed for months or years and only then comes under our observation, our main object will be to perma-

nently arrest the discharge, the hearing being a secondary consideration; since we can, as a rule, do very little towards its restoration. Still the laity consult us usually with reference to the existing deafness, evidently very little concerned about the discharge, and not willing to look upon it in the light of a very dangerous symptom. Unfortunately, very often the hearing becomes worse after the complete cessation of the discharge than it was before, while at times one may be able to effect some improvement in the condition. This, of course, will depend upon the amount of disorganization produced by the long-continued inflammatory process. We, however, desire to remove the "dynamite," so to speak, and give the patient a chance for a longer, a more healthful and a happier life; we aim to restore his mental and physical equilibrium as much as possible.

It is impossible to give even an approximate idea of the time required to cure a case of long-standing otorrhoea without first making a trial. The reason for this is, that we cannot tell exactly the pathological conditions existing, or the amount of surface involved. A cure may be accomplished in from six weeks to one or two years. Again, you will fail, despite your best directed efforts, but you will succeed in the vast majority of cases, provided perseverance and good management be maintained.

The treatment required will be both local and constitutional. Any dyscrasia will have to be sedulously attended to while the local treatment is being carried out; the latter, however, will engage the principal share of our attention. In order to carry out the local treatment, thorough cleansing of the parts is indispensable. To do this properly a head mirror and an otoscope will be necessary, next a syringe having a good-sized barrel with a long, slender nozzle and capable of being manipulated with one hand. The best that I know of is Pomeroy's ear syringe. Lastly, plenty of plain, warm water is needed. It must not be forgotten that pus may be hidden away behind the drumhead which the syringe alone may not dislodge. In order to do this, a few strong inflations with the Politzer bag will usually be necessary, which will generally force these lagging particles into the external meatus, whence they can be readily washed out by the syringe. Cleansing of this kind alone will sometimes cure a long-standing case of otorrhoea; but in the great majority

of cases it will be necessary to supplement this with the use of other agents before one can relieve the infiltration of the mucous membrane and arrest the suppuration. In many cases, even after the use of powerful injections of water, tough mucous plugs and inspissated secretions cling firmly to the underlying tissue, or masses of epidermis lie in the tympanum, forming flakes which are very difficult or impossible to remove by the syringe. In such conditions, the delicate silver ear probe should be used so as to loosen or dislodge them, or it may be necessary to pour a few drops of glycerine into the ear, or, as I prefer, a 50 per cent. solution of boro-glyceride, allowing it to remain in over night; when with the combined use of the probe and syringe next morning there will be generally little difficulty in getting rid of such bodies. It is plain to be seen how necessary it is to remove these deposits, for by so doing you free the inflamed parts of all such sources of irritation, while at the same time you render the diseased surface capable of being brought into direct contact with whatever medicine you may choose to employ. Having now thoroughly cleansed the parts they should be dried well with cotton secured on a probe. A convenient probe for this purpose may be made out of a straightened hair-pin, roughened with a file for a half inch of its end so as to retain the cotton twirled upon it.

The ear being now ready for special medication, the next question will be which, out of the numberless remedies proposed, we are likely to find the most efficacious. I shall first mention some of those which, from personal experience, I have found to be the best. Pure astringents, such as zinc, copper, lead, etc., have always occupied a prominent place in the treatment of otorrhoea. I have long since discarded them for two reasons: (1) because I have had better results with other agents, and (2) because they so often form with the albumin of the mucó-purulent secretions, combinations soluble only with difficulty, and as a consequence of their use there will be formed firmly-adhering deposits in the middle ear which cannot be dislodged even with the most forcible injections, or they may lie in the depressions of the tympanum, where they become hard to remove even with a probe, or they may be entirely beyond the reach of the latter. Antiseptics of late years have occupied a very prominent part in the treatment of this disease for their antiseptic

properties mainly. The agents mostly used in this class of drugs are boric acid, either dry or in solution, the bichloride of mercury in solution, and the peroxide of hydrogen. As to these agents I am compelled to say that they have disappointed me. Others may have a different story to tell, but I do not believe in their utility in this class of cases, apart from their cleansing properties. The value of this latter quality, however, I most heartily admit. Under the administration of these remedies there will often be an apparent improvement, namely, a lessening of the discharge or a stoppage for a time, and hope will arise perhaps that an obstinate and dangerous affection is about to yield; but to your disappointment you will too often find the discharge confronting you after months of this kind of treatment. The peroxide of hydrogen, however, I have found a very valuable aid in certain cases as a most potent cleanser, especially in those cases where there is pus hidden away in the cavity of the tympanum which cannot be reached either by syringe or inflation. It is also valuable in those cases where the syringe seems to act as an irritant or is badly borne, as we find occasionally to be the case. Under such circumstances the peroxide of hydrogen can replace the use of that instrument to a great extent. By instilling five or six drops into the ear with a dropper and churning it by means of a little cotton on a probe, repeating this process until the fluid returning from the ear no longer effervesces, then drying the parts, the ear is made ready for any special application you may desire to make.

Now, with regard to special applications. I have for some time past been in the habit of confining myself almost exclusively, in the course of suppurative processes in the middle ear, to one of three methods, according to indications which will be explained further on. They may be designated respectively as (1) the acid treatment, (2) the alcohol treatment, and (3) the nitrate of silver treatment. I do not pretend by any means to be offering anything original, but am simply endeavoring to emphasize the fact of their respective merits when used with proper discrimination.

The acid treatment is applicable to those cases more especially where we have to deal with caries and necrosis, a condition which is by no means a rare complication, and which when present renders the disease the most troublesome to treat of any form of

otorrhoea. It is well known that mineral acids extract the earthy substance from dead bone, and relying on this fact we aim in those cases of purulent otitis by direct application of the acid to decalcify the diseased bone and so render it absorbable. The diagnosis, however, of necrosis in middle ear affections is often very difficult, owing to the absence of positive signs. You will only too often not be able to get the grating symptom with the probe, because the dead bone may not be in a visible spot, or it may be entirely inaccessible. A very good evidence of the pressure of necrosed bone will be the reappearance of granulations where they have been previously destroyed; but one of the very best evidences of necrosis will be the persistence of the discharge in spite of careful and prolonged treatment. We are indebted to Dr. Bull, of Christiana, Norway, for a very valuable article, which can be found in the *Archives of Otolaryngology* for January, 1889, entitled "The Action of Acids in Caries and Necrosis of the Temporal Bone." The best acids for this purpose are either the nitric or muriatic. Four or five drops of a two to four per cent. solution of either one of these acids are to be dropped into the ear and allowed to remain for half an hour. These instillations may be repeated once, twice, or thrice a week, according to indications, the interim being occupied with proper cleansing with the second agent mentioned, viz., alcohol. I have had also very gratifying results in those cases attended by polypoid growths and granulations. The action of alcohol on these exuberances is often very striking, and on the disease very remarkable. These growths, when visible or accessible, should be removed as much as possible by the snare or curette, under cocaine or ether, followed by the alcohol treatment. Often granulations, though present, may not be visible because of the smallness of the perforation in the drumhead, rendering thorough inspection of the drum impossible, or they may be inaccessible to instruments. In a large proportion of cases of this class, whether we are able to use instruments or not on these growths, by the persistent use of alcohol a marked change for the better will soon be apparent and a permanent arrest of the discharge results. As to its mode of administration: after cleansing the ear as already described, pour five or six drops of absolute alcohol into the ear, the patient lying down and retaining it for from fifteen to thirty

minutes. It is advisable at first to use a 50 per cent. solution until the patient becomes accustomed to its use, when it can be gradually increased to full strength. It may be used once a day or oftener. Another advantage which the alcohol possesses is that it is a powerful germicide, absolute alcohol destroying vitality in exposures of four to twelve seconds; 90 per cent. solution in from twenty-three to thirty seconds, and 66 per cent. in from ten to fifteen minutes.

The remedy, however, with which I have the greatest success and on which I rely in most cases, is nitrate of silver, whether there be caries of the bone, granulation tissue, or simple chronic inflammation of the mucous membrane of the tympanum. At times, no doubt, this remedy, no matter in what strength used, seems to aggravate the disease, and more especially in those cases in which there is a tendency to the production of lymphoid elements, but even such are very often favorably influenced by it. When, however, increased irritation and more abundant discharge is produced, it should be discontinued, and reliance placed on some other remedy. Dr. D. B. St. John Room, in his work on the ear, says that silver is of no value in this disease, unless used in the strength of forty grains to the ounce. My experience has taught me differently. We are no doubt obliged to depart from set rules at times, according to the nature of the case, and in this disease we are occasionally compelled to use very strong solutions—sometimes as high as a saturated solution, before attaining our object; although, in my opinion, these are seldom called for. I usually depend on either a two or four per cent. solution, more frequently the former than the latter.

Nitrate of silver is a powerful astringent and escharotic of moderate strength, and a most potent antiseptic. As to its quality in this latter respect, it may be assigned to a position near the head of germicidal remedies, since one part to ten destroys vitality in exposures of four seconds; one to fifty in exposures of eight seconds; one to one hundred in twelve seconds; one to one hundred and fifty in one-third of a minute; and one to one thousand in four minutes. We find an agent, therefore, in the nitrate of silver, combining essentials requisite in almost every form of chronic suppuration of the middle ear. This remedy should never be entrusted to the laity; the surgeon alone should make each and every application.

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The mode of applying it is as follows: Having first cleansed and dried the ear, instil with a dropper about five drops of a two or four per cent. solution, commencing with a two per cent. usually, the patient's head being held to one side. Allow it to remain in the ear for about five minutes, unless an uncomfortable feeling be produced before the expiration of that time, in which event the ear should be at once syringed with plain warm water. It is not necessary to neutralize the solution by the use of salt and water, simply injecting a small quantity of warm water after each application will be sufficient. Afterwards dry with cotton, and, as a protection from all outside influences, push a little cotton into the meatus. This treatment should be carried out by the surgeon at least three times a week, until a decided impression is made on the disease, when the number of applications may be gradually lessened; the patient or his attendant in the intervening time cleansing the ear as well as may be, according to instructions. A cure should not be expected in a few weeks or even months, especially when we consider the length of time some of these cases have existed. Still we have the gratification at times of permanently arresting a discharge which has existed for the best part of a patient's life; while other cases will yield only after the most patient and painstaking care, occupying perhaps years.

As an illustration of the former kind, I would mention the case of a young girl, sixteen years old, who had had an otorrhoea since she was two and a half years old. Two applications of a two per cent. solution of nitrate of silver arrested the discharge, and up to the present time, now over a year, no return has taken place. In another case, on the contrary, which I dismissed about six months ago, the disease resisted for two years almost continuous treatment and the use of every known remedy before it finally yielded.

In concluding this article, I wish to make the following points: Prepare your patient in the first place for a prolonged treatment and the absolute necessity of three visits a week. The strict observance of the latter should be insisted upon by the physician. Next, on the part of the physician, should be the thorough cleansing of the ear and attention to every detail on each and every visit. And, lastly, the use of either one of the three remedies mentioned according to

indications present as outlined previously. This offers a definite course of treatment, by the observance of which I am convinced that very many cases, which might otherwise be considered incurable or only fit for a mastoid operation, will be found amenable to treatment.

TWO HUNDRED CASES OF OBSTETRICS WITH SOME POINTS OF MANAGEMENT.

BY J. W. HUFFMAN, M. D.,

HASTINGS, NEB.

In the following article it is the intention of the writer to give a record of two hundred successive obstetric cases occurring in a country practice, and also to indicate his method of treatment or manipulation in some of the cases which required the intervention of other aid than that furnished by nature.

As all doctors well know, the majority of cases of child-birth do all right if left entirely to themselves; so in the cases occurring in my practice, the most of them terminated successfully within the prescribed limit of from twelve to fifteen hours, without any outside aid excepting that expression of assurance to the patient and friends of a favorable condition of the case and confidence in a propitious termination.

In the two hundred cases there were one hundred and ninety-four head presentations, one shoulder and five breech. The arrangement of position of head presentation being wholly arbitrary, four positions are assumed, viz., first, occiput to left anterior; second, occiput to right anterior; third, occiput to right posterior; and fourth, occiput to left posterior. It should be stated here that these cases occurring in a country practice, some of them eight or ten miles distant from my office, many were not seen until in the last stages of labor, and some not until the child was born, so that a correct record of all the cases cannot be given. But, selecting 150 cases of head presentations in which labor was observed from beginning to end it is found that 123 cases were of the first position, 3 of the second, 23 of the third and 1 of the fourth. Of the 23 of the third position, 17 rotated in such a manner as to terminate with the occiput under the pubes, or in other words became a second position. The one

in the fourth terminated as a first. Regarding those positions known respectively as occipito-pubic and occipito-sacral, I believe that they are generally changes or rotations from one or the other of the four positions noted, although I would not deny their occurrence as original ones; but I think they are rare. In six of the occipito-posterior positions the occiput rotated into the hollow of the sacrum; four of these were delivered without so much difficulty—although greater than any of the occipito-anterior positions, and fortunately were not followed by any serious results; but the remaining two were the gravest which have occurred in my experience, one requiring embryotomy and both being followed by a train of bad results which will require years to obliterate. As anterior rotation occurs in the majority of these cases the advice given by Professor Penrose is timely: to wait until the head reaches that part of the pelvic cavity where rotation takes place naturally, then by proper pressure on the side of the forehead and occiput or the use of the straight short forceps assist nature in her efforts.

The case of shoulder presentation terminated favorably, resort being had to podalic version, which was accomplished without so much trouble. In this instance the circumstances went to prove that the child was born prematurely, possibly about the end of the eighth month, it being small and poorly developed.

Of the five cases of breech presentation two terminated fatally to the children. The death of the first one was attributed at the time largely to the officiousness of a midwife, who ruptured the bag of waters very early in the labor; but where the second fatal case occurred, about eighteen months afterwards, the presentation being recognized quite early in labor and skilled assistance being obtained to guide the case to a successful issue, the mantle of charity was thrown over the error of the midwife. In the first instance death was in all probability due to placental separation while the head was locked in the pelvic cavity, and in the second case death took place from pressure upon the cord. If any rules could be formulated for the management of breech presentations from the observation of so limited a number of cases (five) they would be to keep the patient as quiet as possible during the first stage and never to rupture the bag of waters. Believing that an ob-

lique position of the head at the superior strait offers the most favorable conditions for a successful delivery in breech presentations, our efforts should be directed during the second stage to a rotation of the proper hip and shoulder into the hollow of the sacrum in order to bring the head obliquely at the superior strait, and apart from these efforts very little else should be done until the head offers at the brim of the pelvis. To facilitate the passage of the head through the pelvis, the patient should be directed to make use of all the voluntary bearing-down power which she possesses, and, having an assistant to support the body of the child if necessary, the attendant should endeavor to supplement this force of the patient by passing two fingers up to the root of the nose and then pressing or pulling down, the fingers of the other hand in the meantime being placed beneath the occiput as a kind of support. This manœuvre will generally flex the head on the chest and may deliver it; but where considerable force is needed, it will be found insufficient for its extraction. Then the first and second fingers of one hand should be slipped into the mouth, the fingers of the other hand should be hooked over the shoulders, and downward traction should be made; while an assistant carries the body of the child backwards over the perineum. As the head descends, the feet should be carried forward over the abdomen of the mother.

In this way I succeeded in extracting the head with considerable facility in the three favorable breech cases which I had. All of these were, however, occipito-anterior positions. Where the occiput lies behind, the child should be carried forward and upward while traction is made as before, so as to force the occiput over the perineum. Another plan recommended by some, but never acted upon by me, is to place the first and second fingers of one hand in the mouth of the child and to make traction upon the lower jaw, while at the same time the other hand grasps the head of the child through the abdominal walls and presses downward in a line with the axis of the inlet of the pelvis. An important element of success in all these cases will be proper flexion of the head, and unless that is obtained at the outset much of our effort will be misdirected. It being essential that delivery of the head should be accomplished very quickly the attendant should have all his methods well in hand and should follow them up systemati-

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cally, as indecision or vacillation for two minutes may result in the loss of the child. The length of time that our efforts should be directed towards manual extraction must be determined solely by the exigencies of the case. Generally if four or five minutes fail a resort to the forceps should be had.

Regarding the management of the perineum in labor, my plan has been of late to let it severely alone. I am fully aware that in this I am disobeying the teachings of eminent authority. But if the accoucheur is to do something—what? For an answer to this, a quotation will be made from Professor Goodell: "On the Management of the Perineum During Labor" [*American Journal of the Medical Sciences*, January, 1871]. "To sum up, then, there are those who make pressure upon the perineum to retard the head; those who make pressure to accelerate its advance; those who deny that any such effects can be produced; and those who conscientiously use support because something must be done. Again; there are those who direct all the pressure at the fourchette; others who reprehend this, and as carefully guard the posterior perineum; and yet others who will not touch the perineum on any account. Further, there are those who push the perineum backwards; and those who, for equally plausible reasons, push it forwards. Some dilate the sphincter vaginae; some the sphincter ani; and some who plug it up. Some place their hands transversely across the perineum; some longitudinally, with the fingers looking downwards; some attack it with their knuckles. Some scoop out the head with the rectis; others drag it out by the ears; and yet others who rely on the forceps. Finally there are those who use the right hand, and those who swear by the left hand. Some who advocate a folded napkin; some an unfolded napkin; and others again who frown down on all napkins folded or unfolded."

In this array of confusion we learn that each one does something, but we are as far from knowing what is the particular thing to do as we were before. The necessity of supporting the perineum in labor has the sanction of time and authority, two things hard to combat, yet when we come to inquire into the results we find that either the support has not been well rendered in many instances or that the perineum will occasionally rupture under any and all methods of

support. And when we examine into the various causes of perineal rupture we find but little argument for prevention by any manipulation of the perineum which we may essay. Among the various causes enumerated are abnormal shape and size of pelvis and vaginal passage, malpresentation or position of child, excessive development of child or of its parts, too great intensity or frequency of pains, abnormal condition of perineum as regards rigidity and dilatability, smallness of vulvar orifice, improper use of instruments, the effects of none of which, as we can see, could be neutralized by pushing on the perineum either up or down or by pulling it either backwards or forwards.

But if it does no good to support the perineum, will it do no harm? Is it a treatment whose effects are evil? I think not. Take a case in which the head is large, the pains strong and frequent, the vulvar orifice small and the perineum stretched to its utmost, then attempt to manipulate the perineum by any method you please, and what is the result? The pains generally become stronger, the head is forced through and there is a laceration, either great or small. You have done the very thing you sought not to do. It is sound obstetrical doctrine to make as few examinations or manipulations as possible. They will excite reflex uterine action. Therefore where there is danger of perineal laceration, any unnecessary manipulation about that structure should be avoided; the labor pains should be restrained by the use of morphine and everything should be done to retard the labor as much as the urgency of the case will allow. Where there is any improper position of head or presenting part, it should be corrected. Here the forceps can be made useful sometimes, both in rectifying a malposition or in retarding the advance of the head; and one should not hesitate to use them if he thinks he can accomplish any good thereby.

While I oppose perineal manipulation for the purpose of support, in the common acceptance of the term, yet I recognize the fact that there are certain cases of labor which can be materially aided in the way of correcting position, or by assisting rotation, or by what is known as the shelling-out process, in which these manipulations (often to be conjoined with rectal manipulation) are useful and necessary. But they are not performed with a view of strengthening an

alternated perineum or increasing the power of its tearing fibres.

In ligating the cord I wait until the child breathes vigorously or placental pulsation ceases; then two strings or tapes are tied around the cord an inch or so apart, the one nearest the child distant about two or two and a half inches; after which the cord is cut between the two ligatures.

After the child is born pressure should be made over the uterus to secure its contraction and the expulsion of the placenta. In the two hundred cases the writer had very little trouble with the delivery of the placenta. The only case giving rise to much trouble was one in which hour-glass contractions of the womb occurred. The treatment consisted in the use of an anæsthetic, the peculiar form of contraction giving way before the woman was wholly unconscious, and the placenta extracted.

SUPPURATION OF GALL BLADDER. CHOLECYSTOTOMY; RECOVERY.¹

BY J. W. KESTER, M. D.,

BLACK EARTH, WIS.

Mrs. S., of Marksville, Wisconsin, 52 years old, the mother of fifteen children (fourteen living and the youngest five years old) was menstruating every two or three weeks until January 1, 1890. During the last months of her menstrual period the flow was very copious and accompanied with much pain. Four years previous to this date the patient was yellow and sick; her urine was yellow and her stools ash-colored. She has looked yellow at different times since. She complained all last winter of pain in the right side and a general failure of health, with frequent chills and bowels generally constipated, but she has had diarrhoea during the last three weeks. Three weeks before this date the patient had a severe vomiting spell which lasted five days, ejecting a greenish bitter fluid. She had noticed a slight swelling over the crest of the ilium for some time previous, but now finds a swelling in the right lower abdominal region.

I first saw Mrs. S. April 30. She complained of pain and tenderness in the right iliac and lumbar regions. Her pulse was

120; her temperature 102°. My diagnosis was acute suppurative inflammation. I gave quinine and iron, and an opiate to relieve pain. I advised consultation with Dr. Jackson, of Madison. May 1, I saw Dr. Jackson, and we agreed that an exploration was necessary. I prescribed castor oil to move the bowels and a general and thorough bath. May 2, I saw the patient for the second time, being accompanied by Dr. Jackson. The bowels had moved twice the same morning. The woman's cheeks were flushed; her pulse was 100, quick and wiry; her respirations 22; her temperature 99°. She complained of great pain and tenderness in the same region as before. Examination revealed tumefaction in the right inguinal and hypogastric regions, extending upwards into the lumbar and umbilical regions. Swelling was about the size of a large cocoanut, with a doughy, non-elastic feeling, excepting at two points where fluctuation could be felt: one point in the centre of the right inguinal region, the other at the right and above the os uteri.

Dr. Jackson and I agreed as to the previous diagnosis in regard to acute suppuration, but were somewhat uncertain as to the precise organs involved. We were also agreed as to an exploratory incision. I gave a hypodermic injection of morphia and atropine and put the patient under chloroform; cleansed the whole field of operation with soap, turpentine and water, shaved pubes, etc., and with antiseptic precautions did the following exploratory operation. I introduced a large-sized aspirating needle into the most prominent part of the tumor, and through it obtained a little pus. Dr. Jackson then made an incision of three inches downwards and inwards in the line of the fibres of the external oblique muscle. Through this between twenty and thirty ounces of pus escaped. Examination with the finger revealed a cavity with hard thick walls on either side with diverticula or sinuses extending in various directions. A rubber catheter introduced would penetrate upwards and backwards many inches. At the bottom of this cavity lay, as if in a nest, a number of small hard bodies which could be felt by the finger, and upon their extraction by means of the scoop, aided by a free irrigation of a solution of boric acid, proved to be gall stones. In all fifty-three were removed, and probably others were lost. The cavity was then freely flushed with a boric acid solution, curetted, and swabbed

¹ Read before the Central Wisconsin Medical Society, June, 1890.

out with sponges dipped in a weak bichloride solution; much broken down tissue and debris being thus removed. No bile or feces were discovered. But from the bottom of the cavity was extracted a white hair of several inches in length, a part of the hair being broken off and left in the tissue. A large rubber drainage-tube was introduced and secured. The incision in the abdominal walls was secured with five sutures; an antiseptic dressing of iodoform, sublimate gauze and absorbent gauze was then applied. The calculi removed ranged in size from a dried pea to a large hazel-nut, dark olive in color, intermingled with a golden tint.

On May 3 the woman's temperature and pulse were normal. On May 4 I dressed the wound, washing out the cavity with a boric acid solution. At this time I washed out three more stones, and the remainder of the hair. From this time on the patient made a slow but steady recovery, and she has gained considerable flesh, and is growing quite stouter. The deep abdominal silk sutures still remain and their ends hang out through small button-holes. With this exception the wound is healed and has been so for some weeks. I am at present having daily traction made on the sutures. They are gradually giving way and in time will become loose.

PERISCOPE.

Use of Dog's Skin in Skin-Grafting.

Dr. M. E. Van Meter, of Red Bluff, Colorado, reports in the *Annals of Surgery*, August, 1890, the case of a boy, fourteen years old, who in April last sustained severe and extensive burns, and under treatment had accomplished the healing of them all except certain granulating regions beneath the chin and lower jaw, and the right arm from elbow to fingers. Upon these surfaces skin grafts were finally placed. For the neck, grafts were obtained from the arms of the father and brother of the patient; but for the arm, grafts were taken from two young puppies of the Mexican hairless breed, whose soft white hairless skin seemed to offer itself for the purpose with good prospect of successful result. The result was all that could be desired. The puppy-grafts proved to be superior to the human grafts; a greater proportion of them "took," and their subsequent rate of growth was much faster.

This use of puppy-grafts was original with the reporter of the above case, and when he communicated it he was unaware that any similar case had been recorded. But in the *Lancet*, March 15, 1890, however, a similar case is reported by Mr. Alexander Miles, of Edinburgh, of which a full account was given in the *MEDICAL AND SURGICAL REPORTER*, May 31, 1890.

The *Annals of Surgery* gives an abstract of the case (crediting it to "Dr. Milro," however), which may interest those who have not seen the original report. A boy, ten years old, presented an extensive ulcer on the left leg, resulting from a burn. The entire surface was covered with healthy granulations, but there was not the slightest attempt at cicatrization. It being impracticable to obtain sufficient human skin to cover the ulcers, a young black and white greyhound, seven days old, was killed with chloroform, and, the whole of his anterior abdominal wall and flanks having been shaved, the flap of the skin thus marked out was dissected up, taking the entire thickness, leaving the subcutaneous fat. The skin was cut into strips measuring six inches long by half an inch broad, which were firmly pressed into the previously cleaned ulcer in the long axis of the limb. Smaller grafts, about an inch square, were used to fill in spaces left between the larger ones. A considerable area over the inner side of the knee still remained bare, and, to cover it, the skin from the pup's tail was dissected up, unshaven. Over these grafts an antiseptic dressing was applied.

On the first dressing, three days later, all the grafts but one small one had adhered. Some of the long strips sloughed later, but the smaller ones all did well. It was observed that the graft taken from the tail, which was not shaved, behaved exactly as the sponge does by promoting granulation. The hairs around the margins seemed to stimulate the granulations which grew on to the surface of the graft, and then spreading, completely swamped it. A few small grafts of human skin from a small boy were scattered here and there, two weeks later, to fill up gaps still left, and all did well. One or two spots still remaining a couple of days later were covered with pieces of the skin of an old frog, but these failed to unite.

Cicatrization was complete in six weeks after the first application of grafts. Seven months later there was absolutely no cicatricial contraction except where the tail skin

was planted, and there it was very slight. The color of the skin was uniform and very similar to that of the normal skin. There was no evidence of any development of hair or of cutaneous secretions. The ordinary sensation was as good as in the other leg, and the temperature of both was the same.

The author believes the favorable outcome of the case to be mainly due to the age of the animal selected to furnish the grafts. In the first few days of extra-uterine life the creature grows very rapidly, and by grafting a large area of young tissue with a potentially great developmental power, the ulcerated area is quickly covered in and the contraction prevented which invariably results after extensive burns when they are allowed to heal without artificial aid.

Operation for Prolapse of the Rectum.

In the *Annals of Surgery*, April, 1890, Dr. John B. Roberts proposes and describes how he conducted, in the case of a young woman, an operation for proctorrhaphy which seems to meet all the indications. The anal aperture was so dilated that he could readily insert the ends of the five fingers of his hand into the rectum. When the bowel was prolapsed it protruded from the anus as a sausage-shaped mass about four inches in length. He then determined to cut out a V-shaped portion of the posterior wall of the rectum, the apex of the V being upward, and at the same time to diminish the anal aperture by excising a part of the sphincter muscle. This procedure would diminish the caliber of the lower part of the rectum and give it a narrow orifice; so that the inferior portion of the intestine would diminish in diameter, as it approached the anus, instead of being a tube with a wide, almost funnel-shaped, lower opening through which prolapse was constantly occurring.

The steps of the operation were as follows: Making a small incision in the middle line near the point of the coccyx, he introduced his finger and broke up the cellular connections behind the rectum, as is done in preparing to excise its lower end for carcinoma. The sphincter muscle was then divided in two places by incisions each about a half inch away from the posterior median line. By carrying these incisions obliquely backward through the skin until they met at the original incision near the

tip of the coccyx, he included between them a triangular portion of tissue which had as its base about one inch of the anal sphincter. With scissors he then cut from the posterior wall of the rectum a long triangular piece consisting of the entire thickness of the wall. The apex of this V-shaped section was situated about three inches up the gut, while its space corresponded with the space between the incisions by which one inch of the sphincter muscle was removed.

After hemorrhage had been controlled with catgut ligatures, chromicized catgut sutures were used to bring the divided wall of the incised rectum together. The first suture was introduced at the apex of the wound, that is, three inches above the anus, and was tied with the knot *within* the bowel. Successive sutures were inserted, with intervals of about one-third of an inch between them, until the lower margin of the rectal wound was reached. The last intra-rectal suture was placed just inside the margin of the anus. They were all tied upon the mucous surface of the bowel so that the knots were within the lumen of the intestine. In this manner the lower portion of the rectum was greatly reduced in diameter. The divided ends of the anal sphincter muscle were then brought together by two catgut sutures and one wire shotted suture. The anal aperture was thus reduced, so that it was barely possible to introduce the tip of one finger; whereas originally five fingers could readily be thrust into it. A rubber drainage-tube was then introduced into the cavity between the rectum and the sacrum, and the wound leading backward from the anus to the coccyx was closed with numerous shotted wire sutures carried deeply by means of a strong and curved cervix uteri needle.

The result of Dr. Roberts' operation was not very good; but this fact he attributes to a diarrhoea and the entrance of fecal matter into the wound.

Keloid.

The *Edinburgh Medical Journal*, August, 1890, says Leloir and Vidal have contributed some interesting facts to our previous knowledge of keloid. They describe the spontaneous and the cicatricial forms, and add what has been often confused with these, an account of hypertrophic scars. In spontaneous keloid the number of the individual

growths is sometimes very great. Thus, in a case observed by Amicis there were 318, the greater number spontaneous, but a certain portion secondary or cicatricial. They were arranged nearly symmetrically, and were most numerous on the arms. Examined microscopically, the epidermis and its interpapillary cones preserve their normal aspect. Keloid, unlike cicatricial tissue, arises in the corium, up to that time intact, and is, consequently, not a formation destined to repair a loss of substance. The persistence of the interpapillary cones and of the papillæ is not met with in the secondary or cicatricial keloid, and is limited exclusively or nearly so to the true or spontaneous form. The authors, after careful examination, have not been able to find any alteration in the nerve filaments or to discover the smallest microbe. Cicatricial or secondary keloid is that which is developed in the thickness of a scar. It begins below the cicatricial neoplasm or at a point in its margin, but the ultimate growth has no connection with the extent of the scar in which it has arisen. Kaposi has stated that the hypertrophic scar closely resembles keloid, but the authors do not accept this view. An hypertrophic scar is usually redder, more vascular, and not so hard as keloid. The latter, once removed, recurs almost constantly in the cicatrix left after the operation, or in the course of the stitches, excision of hypertrophied scars cures them completely, or they may spontaneously disappear. The authors have seen two instances of recent cicatricial keloid cured under the continued and regular application of mercurial plaster. The true keloid they find is best treated by repeated scarifications carried nearly as deep as the growth, and not more than two or three millimetres beyond its margin. These must be continued till there is a uniformly pliant and thin cicatrix. Should a nodule of induration not larger than a pin's head remain, this little by little enlarges, and the neoplasm recurs. The scarifications are to be two millimetres apart, and crossed at right angles. The pain can be much lessened by painting the part once or oftener with chloride of methylene.

Fissure of the Anus and Masturbation.

Dr. A. Grimm says, in the *Cincinnati Lancet-Clinic*, September 13, 1890, that the comparative infrequency of fissures of the

anus in childhood, and still more the exceptional instances in which these have been known to cause masturbation, prompt the report of the following interesting case.

A female child, not quite eleven months old, was brought to him with a history of masturbation of three months' standing. The child was well developed and, with the exception of a certain degree of anemia and puffiness about the face, seemed to be perfectly healthy. Before the true nature of the affection was recognized, the mother had often noticed the child while in a state of momentary abstraction suddenly stiffen and relax in her arms. Gradually the symptoms became more pronounced. A certain definite position on the arm was sought; the shoulder of the mother would be firmly grasped, and with flushed face and quickened breath a seesaw motion commenced, lasting till the acme of orgasm was reached. If on the floor, the little sufferer would steady the body with her hands, and inclining towards the right side tightly press the legs together. A jerky to-and-fro movement would now begin, the face, as before, flush, and while groaning and panting, and bathed in perspiration, the orgasm would come on, often followed by a fit of crying or quiet sleep. So entirely oblivious of her surroundings was the child, that neither the presence of strangers nor scolding nor terrorizing could interrupt the action. The attacks would occur from five to ten times a day, but never during sleep. The physician who had first been consulted ascribed the symptoms to the possible presence of pinworms; but anthelmintics proved of no avail.

An examination of the genitalia revealed a slight swelling of the labia majora and a good deal of redness of the introitus vaginalæ, with increased moisture. As all symptoms referable to the rectum, such as painful defecation, bloody stools or constipation, were absent, the treatment was directed towards allaying the apparent hypersensitiveness of the vaginal tract. Bromide was ordered internally, and cocaine in solution and salve applied externally. Though the vehemence of the symptoms seemed to abate somewhat, a cure was not effected.

At this juncture Dr. Forchheimer was called in consultation. A careful examination of the genitalia was made, but the findings were pretty much the same as before described. Passing, however, his hand over the anal region, an induration was distinctly felt, and on forcibly opening the anus sev-

eral linear fissures were seen just within the sphincter. Success seemed now insured, and a favorable prognosis given. Most authors agree that anal fissures in children are more amenable to treatment than the same affection in the adult, and the heroic measures so frequently necessary in the latter are hardly ever called for in the former. Weak solutions of nitrate of silver and light touching with the solid stick of nitrate were employed, the parts were always kept well smeared with an iodoform salve and the bowels maintained in a soluble condition. But the fissures would not heal. At last, disgusted with the ineffectual results of this method, surgical interference was advised and accepted. Dr. E. W. Walker was called in consultation and practiced division of the sphincter. An iodoform tampon was daily introduced into the rectum by means of the speculum, and in two weeks the ulcers healed and masturbation was no longer indulged in.

At this period the child was, unfortunately, taken ill with chicken-pox. Not only was the skin studded with the characteristic vesicles, but the mucous membranes of the mouth and pharynx also participated in the eruption. The disease had scarcely subsided when the child resumed the former practice of masturbation. An inspection of the anal region revealed the same, if not a worse, condition than before, and, without further temporizing, Dr. Walker was again called to divide the sphincter. The fissures healed as kindly as in the first instance, and with their disappearance masturbation also ceased. In searching the literature, Dr. Grimm was unable to find a parallel case. The *American Journal of Obstetrics*, vol. ix, 1876, contains the report of a case of masturbation, by A. Jacobi, in a female child nine months old. In this instance, however, the practice became established through a state of chronic constipation.

The remarkable features in the case just presented are the age and sex of the child, the severe measures that had to be adopted for the cure of the fissures, the entire absence of rectal symptoms, and, lastly, the rekindling of the disease during or immediately after an attack of chicken-pox. As regards the latter point, Dr. Grimm is inclined to believe, rare though it may be, that an eruption similar to the one existing in the mouth also invaded the rectal mucous membrane, and in this manner reproduced the pathological conditions.

The Cure of Leprosy.

The *Druggists' Circular*, September, 1890, says: The cure of a case of leprosy is reported by Dr. Sandreczky, of Jerusalem. It was that of a child of eight years, in whose family and connections leprosy had never occurred. He was under treatment for four years, and it was directed upon general principles, such as fresh air exercise, massage, iron and quinine; bathing with green soap, sulphur, iron, or salt, the water being very hot and the bath being followed by free sweating under proper covering. The tubercles were treated with chrysarobin, green soap, or iodine without any effect. After two years of general treatment marked improvement showed itself. There has been no relapse, and all signs of the disease have disappeared excepting the atrophy of the hands, which is, of course, permanent.

Antidote for Strychnia.

At the British Pharmaceutical Conference, September 2, 1890, Mr. Siebold made a verbal communication regarding the antidotes of strychnine.

In this he explained, as stated in the *Chemist and Druggist*, September 6, 1890, that he had taken fifteen-minim doses of liquor strychninæ, sufficient to produce contraction of the terminal muscles, and had followed the doses, as soon as the symptoms appeared, and sometimes before, with doses of the various antidotes. Tannin in ten-grain doses was perfectly valueless. Charcoal in one-ounce doses did have some effect, but not much; whereas chloral hydrate and chloroform sufficed to entirely prevent the muscular contractions if taken in time; and injections of morphia were also useful.

Foreign Students in France.

According to the *Gazette Médicale*, of Paris, August 2, 1890, there were registered in the second trimester 908 foreigners who were studying medicine in France; of whom 822 were in Paris. Of the latter there were: from Russia, 261; the United States, 159; Roumania, 85; Turkey, 71; England, 51; Spain, 34; Greece, 34; Switzerland, 25; Servia, 20; Portugal, 18; Egypt, 13; Italy, 12; Bulgaria, 8; Austria, 7; Belgium, 7; and Holland, 60.

THE MEDICAL AND SURGICAL REPORTER.

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CHARLES W. DULLES, M.D.,
EDITOR AND PUBLISHER.

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When it is desired to call our attention to something in a newspaper, mark the passage boldly with a colored pencil, and write on the wrapper "Marked copy." Unless this is done, newspapers are not looked at.

The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

PROTECTION OF WATER SUPPLIES.

It is a curious and somewhat alarming fact that the city of Newark has recently protested in vain against the introduction into the Passaic River of the sewage of the city of Passaic, which is situated only four or five miles above the intake of the water-works of Newark. Afterwards the Aqueduct Board applied to the Chancellor of the State for an injunction to restrain the city of Passaic from discharging its sewage into the river, alleging that such discharge would materially pollute the water to the injury of its business, and the health of its inhabitants. This application was denied, and on an appeal to the Aqueduct Board of New Jersey Court of Errors and Appeals the decision of the lower tribunal was affirmed.

Our contemporary, the *Engineering and Building Record*, August 16, 1890, rightly

says that this case, involving as it does, the right of municipalities to use navigable streams for sewage disposal and water supply, is of great interest to all who are either officially or professionally concerned in such matters.

The grounds upon which the application for an injunction was denied were, 1. That the water of the Passaic River, where the tide ebbs and flows, belongs to the State, for uses common to all its citizens. 2. That the city of Newark has no special rights in that water, either by reason of its riparian ownership on the river, or by grant from the State, which may be injured by the apprehended nuisance, and enable the complainant, by showing an apprehended injury, distinct from that which will be suffered by the other inhabitants of this State, to maintain its individual suit to restrain the nuisance.

3. That, at best, such special rights have not been established by adjudication in this State. 4. That the complainant is not in position to ask for a preliminary injunction when the right on which it founds its claim is, as a matter of law, unsettled. 5. That the proceeding in equity to restrain a public nuisance is by information of the Attorney-General. 6. That the statutory authority to the complainant to maintain a suit in equity for nuisance to water-courses connected with its works, did not constitute it a public agent to sue to restrain a public nuisance, but merely clothed it with power to sue, as an individual might, for the protection of private property. 7. That an injunction to restrain a nuisance will issue only in cases where the fact of nuisance is made out upon determinate and satisfactory evidence, and that, if the evidence be conflicting, and the injury be doubtful, that will constitute a ground for withholding the injunction. And if the nuisance be merely apprehended, it must appear that apprehension of material and irreparable injury is well grounded upon a state of facts which show the danger to be real and immediate. 8. That such conditions of fact do not appear in this case.

We cannot spare space to reproduce the excellent article in the *Engineering and Building Record*, upon this subject; but would refer all of our readers especially interested in the matter to consult it for themselves. This much, however, from the medical standpoint we may say: that it must be regarded as a very serious misfortune that any law, or lack of law, should come between the inhabitants of any city and the protection of their source of drinking water from pollutions dangerous to health. In general the rights of those who must drink water from any stream, to its protection against contamination, are beyond question; and it seems contrary to reason—it certainly is contrary to common-sense—that the fact that water moves in two directions should alter the rights of those dependent upon it for their drinking supply.

We trust that some way will yet be found to protect the city of Newark against any such dangers as now threaten it. More than this, we trust that the time will arrive when no city will be willing, if permitted, or permitted if willing, to discharge its sewage into a stream. It is only a question of time and cost when all the sewage of cities will be either rendered innocuous, or utilized for agricultural or other purposes; and the saving part of such occurrences as are reported from Newark consists in the fact that they probably will hasten that day by the very wrong which they inflict.

HOSPITALS FOR THE TREATMENT OF PHTHISIS.

In a brief paper presented to the Medical Section of the Tenth International Medical Congress, recently held at Berlin, and published in the *Münchener Medicinische Wochenschrift*, August 26, 1890, Dr. Hermann Weber, of London, considers the treatment of phthisis, and makes an earnest plea for the establishment of institutions for the exclusive treatment of poor phthisical patients. As yet we know of no specific remedy for

phthisis. If a disease cannot be attacked directly it must be combatted by strengthening the entire organism including the diseased focus. It is a recognized fact that the greater the want of cleanliness and the larger the number of persons present in any cubic space, the larger will be the number of microbes. Suitable ventilation diminishes this number. Thus the indications in the treatment of such a disease as phthisis are: to support the general nutrition; to control cough, fever, hemoptysis and sweats; and to disinfect the air of the rooms in which patients live.

No class of cases requires more constant observation than consumptives do. On this account their treatment in institutions devoted exclusively to that object possesses, Dr. Weber rightly says, great advantages for most patients, and constitutes for many a condition necessary for convalescence.

In this connection climate becomes an important element. In the great altitudes of mountainous regions the air is clearer and more dilute, the barometric pressure is less, the amount of moisture is slight, the temperature is lower, there is much sunshine, and the wind is relatively still in winter. Here out-door exercise is almost always safely possible and the appetite improves. The dryness and coolness of high regions causes increased pulmonary activity and secretion with increased cardiac action and pulmonary circulation, and the expansion of healthy lung structure exerts a curative influence upon adjacent diseased tissue.

In the selection of a residence for a phthisical patient, Dr. Weber says, the following points should be considered: the air should be as free as possible from dust and organic impurities of all kinds; the soil should be dry; a southern or southwestern exposure should be selected; the dwelling should be high above the valley and the water-level, and, if possible, close to a wood, especially a pine wood. The place should be one on which there is abundant opportunity for physical exercise and for

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suitable employment, and provided with protected walks and seats. Rooms for patients should have a sun exposure, be well ventilated and amply large. For weak patients with fever there ought to be verandas with beds or lounges for use during the day.

The establishment and maintenance of institutions for the care of the poor phthical would entail the expenditure of large sums of money, but the advantages derived from them would more than compensate for the additional expense. The condition of the patients would be alleviated and the condition of their families would be much improved. By timely treatment not a small proportion of patients would be cured entirely, or to such a degree as to become capable of work. The patients would learn a mode of living and acquire habits which would guard them against new attacks or relapses. They also learn how to dispose of their sputa so that it shall not be dangerous to others, and so the community is a gainer. Meanwhile general hospitals are by so much relieved of pressure and made free for the treatment of acute diseases. In all, it is clear that special hospitals for the treatment of consumptives are one of the great needs of the present day.

MEETING OF THE ORTHOPEDIC AND OBSTETRIC ASSOCIATIONS.

The American Association of Obstetricians and Gynecologists which recently has held its third meeting in Philadelphia, gathered together a large number of medical men from the West and South, as well as from the middle section of the country. Men well known in these departments read papers and discussed subjects belonging to their specialty, and entertainment for them was provided by the officers of the society residing in Philadelphia.

The meeting of this Association was held at the same time as that of the American Orthopedic Association which had a most interesting and valuable meeting, with social

features which were more than usually successful. The simultaneous meeting of these two societies demonstrated the convenience with which such bodies can be entertained in Philadelphia, where the building of the College of Physicians furnished room for both societies without inconvenience to either, and also access to books and specimens of great interest in the Library and Museum of the College. Aside from the acquaintance with Philadelphia medical matters gathered by a visit to this city, the members of visiting medical societies have an opportunity to see a library and a museum unsurpassed in this country, and learn something of a society which is the oldest, and in many respects the most distinguished, medical body in the United States.

ELECTRICAL TREATMENT OF GOUT.

At the Tenth International Medical Congress, Mr. Edison made a communication through Dr. Bayles, who represented him in the dermatological section, in which he urged the importance of using electricity to promote the distribution of gouty concretions. He described experiments by which the process of osmosis in animal membranes has been very much facilitated by the passage of an electrical current through the fluids and the membrane. This suggested to him the attempt to produce absorption of lithium salts in the immediate vicinity of the gouty accumulations. In one case he placed one hand of a healthy man in a solution of chloride of lithium, and the other in a solution of chloride of sodium, and connected the negative pole of a battery with the salt solution and the positive with the lithium solution. The current had a strength of four milliamperes and lasted for two hours every day until a total application of eleven hours had been made. Spectroscopic investigations showed that considerable portions of lithium were excreted in the urine. Edison next undertook the treatment of a man seventy-three years old who had very obvious

chalky concretions near his joints, especially the finger joints. In this case the treatment consisted in the application of electricity passing through solutions of chloride of lithium (1.08 per cent.) and chloride of sodium, the current having a strength of one hundred and twenty volts and a resistance of five thousand ohms, the patient bearing a current of twenty milliampères without inconvenience; and this was applied four hours a day for six days. At the end of this time the diameter of the finger which was used as a test was found to have been reduced one-half a centimeter; the pains had disappeared on the first day. Further application of the current reduced the diameter of the finger somewhat more.

This experiment is more interesting than conclusive. It has been long known that medication could be introduced into the system by means of the skin, if an electrical current were used to promote its absorption. What part of the action in the case described was due to the lithium which entered the economy, and what part to the local action of electricity, it would be hard to say until some comparative experiments have been made in regard to this subject. But the matter is one which deserves careful attention, and invites, we think, further experimentation on the part of medical practitioners familiar with the application of electricity and its capabilities as a remedial agent.

AMERICANS AT THE BRITISH MEDICAL ASSOCIATION.

In the *REPORTER*, of August 30, 1890, attention was called editorially to the report that a large number of American physicians had left Birmingham dissatisfied with the way in which they had been treated there. Conflicting accounts of this occurrence have come to this country; but the substance of it appears to be that a few medical men from this country, desiring to be elected to membership in the British Medical Association, presented their names or had them presented

for them. Certain of them were not passed upon immediately, but were referred to the Council for inquiry as to the standing of the candidates in their own country and their fitness for membership in the British Medical Association; whereupon these men and some of their friends became indignant and left Birmingham. Some accounts say there were only a few who did so, and that the whole trouble was about one man who is far from being a fit representative of the profession in this country. Other accounts say that several names were referred to the Council and that the number of malcontents was as high as twenty, or perhaps more.

In any case, the facts show how foolish was any claim that Americans, as Americans, had been treated with discourtesy. There was absolutely nothing for Americans to be angry about. But it is not surprising that men so unwise as to take offense at the exercise of such a sound discretion as the British Medical Association showed in regard to making Americans—of whom they have had in times past, we believe, some unfortunate experiences—members of their Association, should try to exaggerate their personal grievance into an international episode. As we have not access to the names of those who did this thing, it may not be invidious to say this much, and to hope that hereafter no Americans will try to get into the British Medical Association, except such as have the sense to understand that the Association is not bound in any way to take them in merely because they are Americans.

—Sodium silico-fluoride has been stated to be a comparatively harmless yet powerful germicide, if taken in solution, the dose being given at one-half to one grain. Recent experiments, however, show that, while a 1 in 750 solution does prevent fermentation, it is by no means harmless as a medicine. The immediate results of its administration are an irritated condition of the mucous membrane of the stomach.

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BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the *REPORTER*.]

PRACTICAL SANITARY AND ECONOMIC COOKING ADAPTED TO PERSONS OF MODERATE AND SMALL MEANS. By MRS. MARY HINMAN ABEL. The Lomb Prize Essay. Small 8vo, pp. xi, 190. Published by the American Public Health Association, 1890. Single copies, in cloth, 40 cents; in paper, 35 cents.

Mrs. Abel's essay was awarded the prize by the American Public Health Association. There were seventy competitors. So far as we have been able to judge by a pretty careful examination it fulfils reasonably the promise of its title.

In looking over the diet-tables for the first, or poorest, class, we are struck by several things. Breakfasts consist chiefly of pan-cakes, milk-toast and oat-meal. These are "filling," yet not very sustaining foods; that is to say, it would take a great deal of them to provide nourishment and vigor to carry a working man or woman to the dinner hour, and we fancy any family that should try to adhere strictly to the programme would often be hungry before noon. The whole of the dietary is open to the objection that it is not appetizing; and we would like to know if there could be found anywhere in this country a family that would stick to it. One set of meals for a family of six is estimated to cost seventy-eight cents a day. This is a good deal to pay for food alone, considering that many persons of this class do not earn more than a dollar or a dollar and a quarter a day, and must pay rent and find clothing out of that sum. However, most American work-people can afford it. On the other hand, it shows the better condition of working people in this country; for abroad the price of a day's work is frequently less than the estimated cost, according to Mrs. Abel, of a day's food-supply in America. As to the diet-tables in general, it may be of interest to remark that they are so rich in starchy foods as to make acid stomach dyspepsia a danger. A larger supply of meat, fat and green vegetables would prevent this, but would also considerably increase the cost. Perhaps the author has given the best diet for the money.

HOW TO PRESERVE HEALTH. By LOUIS BARKAN, M. D. Small 8vo, pp. 344. New York: American News Co., 1890. Price, cloth, \$1.00.

Dr. Barkan has produced a book which is admirably clear and concise in its style, and is full of sound advice. He has hit the happy mean of giving definite and specific directions for the care of the health, without seeking to come between the doctor and his patient and being accepted as a compendium of all medical knowledge on hygienic subjects. There are some statements to which exception might be made, and more concerning which there is room for a difference of opinion; but withal it is a very useful book, and one that can be read with profit, both by physicians and by laymen.

LITERARY NOTES.

Owing to the removal of Dr. H. Longstreet Taylor, the Editorial Department of the *Cincinnati Medical Journal* will be under the direction of Dr. Gilbert Collins, commencing with the August number.

CORRESPONDENCE.

To Save the Edge of Sterilized Instruments.

TO THE EDITOR.

Sir: While attending Prof. von Bergmann's surgical clinic at Berlin recently, the following demonstration was made, which will certainly interest your surgical readers.

To render instruments perfectly aseptic, and to preserve the cutting edges from oxidation, they are boiled for five minutes in a one per cent. solution of carbonate of soda. They can remain in this solution indefinitely without rusting or dulling the cutting edge. When required for operation they are taken out, dried with a sterilized piece of gauze, and handed to the operator. Whenever, in course of the operation, they come in contact with anything not aseptic, all that is required to re-sterilize them is to dip them for a few seconds into the boiling solution of sodium bicarbonate.

Yours truly,

JOHN S. MILLER, M. D.

Philadelphia.

Vital Statistics.

TO THE EDITOR.

Sir: You will no doubt agree with me when I say that reliable mortality statistics are essential to public health. Prussia and Switzerland recognize the importance of this and have a systematic registration of all the deaths that occur in their city and agricultural populations. The only fairly reliable statistics in this State are those gathered by the cities of Philadelphia and Pittsburgh. Such work is not even thought of in the town and rural districts—which embrace the large majority of our people—except by the census enumerator, who makes a shrewd guess once every decennium. Now it occurs to me that a uniform system of death statistics could be obtained if each clergyman throughout the State were required by law to note the cause of death of each body he buries, and return a record of this to the State Board of Health office at regular intervals of a month. This could be done very conveniently; for it is the custom already in most, if not in all, of the churches, to record all the baptisms, marriages and deaths, hence with the little additional work

of adding the age and cause of death in each instance, we would obtain very satisfactory mortuary statistics of this State—since few burials occur outside the jurisdiction of the churches. I offer this as a suggestion and would be glad to hear from you concerning it.

Yours truly,
THOMAS J. MAYS, M. D.

Philadelphia.

[Anything which would contribute to the formation of accurate vital or mortuary statistics would be a distinct advantage to science. The suggestion of Dr. Mays, if practicable, would be worth trying. We have doubts of its practicability, however; because we believe the statistical returns now a part of the duty of clergymen are very imperfectly made, and we would hardly expect that they would do better if more work were imposed upon them. The best source of accurate returns, we think, are physicians' certificates, and would be glad if stringent laws forbade any burial or cremation in, or removal of a dead body from, the State without the registration at an office designated for that purpose of a physician's certificate giving the actual cause of death. A plan for securing this in Philadelphia was presented to the Philadelphia County Medical Society by a committee which had carefully studied this subject. The recommendations of this Committee will be found in another part of this number of the REPORTER.]

NOTES AND COMMENTS.

Vital Statistics.

The following embodies the substance of a report made to the Philadelphia County Medical Society by a Committee on Vital Statistics, which had studied the subject for more than a year.

In order to secure better vital statistics, the first thing to be done is to define the duty of physicians, and afterwards to inquire what methods we may with propriety ask the health authorities of the city to adopt, in order to insure greater exactness and convenience of reference in the tabulated statements of the Board of Health. Physicians should understand that they ought to report as to the cause of death: (1) the disease with which the patient was afflicted; (2) any complication of moment; and (3) the immediate cause of death. As to the first, the plain truth should be stated, and no evasion should be made out of regard to a natural wish of relatives to hide what may not be pleasant. Further, the physician should avoid the unqualified use of vague expressions, such as "heart-failure," "convulsions," "bowel-complaint," etc., and should

try to state the precise disease in scientific terms. It is important also to mention complications; such as endocarditis with rheumatism, and strangulation with hernia. The physician should likewise distinguish between the disease and the immediate cause of death; as, for example, where typhoid fever leads to hemorrhage in the bowels and this to death, the latter should be named as well as the former; or, in a case in which rheumatism was complicated with pericarditis, and the immediate cause of death was hydropericardium, the report should state all these facts. The physician should endeavor to restrict himself to terms approved by the Board of Health in making his reports, and to do all he can to aid the Board in securing accurate and trustworthy statistics.

In reference to the part to be borne by the health authorities in the work, the Committee made the following suggestions:

1. The reports of deaths in Philadelphia shall be tabulated week by week according to the date of death, and not of interment (as at present done).

2. No burial, cremation, or removal of a body from the city shall take place until after a permit has been granted by the proper Health Officer, and the permit shall not be granted until a satisfactory death certificate has been deposited at the Health Office.

3. The blank book containing forms of certificates shall contain a list of terms to be used by physicians in reporting causes of death.

4. Each blank certificate shall provide space for the—

1. Name of deceased (full name).
2. Color " "
3. Sex " "
4. Age " " (years, months, days).
5. Social condition of the deceased (single, married, widowed).
6. Residence of deceased (ward, street and number).
7. Date of death.

8. Cause of death { Disease.
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of death.

9. Duration of last illness.

10. Name and address of physician signing the certificate.

It is suggested that the form of blank be made out somewhat as follows. Each blank shall be divided into three divisions:

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2. For the permit of burial.
3. For the physician's certificate.

Such a certificate shall be first filled out in his part by the physician. It shall then be taken to the Health Office by the undertaker. Here a registration number shall be marked on each part of the certificate (the same number being used for each part), and the physician's certificate shall be detached and kept by the proper officer for registration and reference. The permit shall then be filled out and given to the undertaker, who shall detach it and present it to the superintendent of the place in which burial (or cremation) is to take place. The undertaker's certificate shall have blank to contain the—

1. Name of deceased.
2. Nationality of deceased.
3. Residence of deceased.
4. Date of death.
5. Name of physician in attendance at death.
6. Date of burial (or cremation).
7. Place " " (" ").
8. Name and address of the undertaker.

This certificate shall be filled out by the undertaker and shall be returned to the Health Office immediately after the burial or cremation has taken place. The permit shall be retained by the proper officer of the place of burial or cremation.

In order to secure greater accuracy in returning the causes of death, it has been proposed above to suggest to the Board of Health to print in every book of blanks for death certificates a list of terms approved by the Board for use in tabulating vital statistics, and the Committee prepared and reported such a list, and asserted its belief that with a careful and conscientious use by physicians of the terms contained in this list it would be easy for a Board of Health to collect accurate vital statistics.

Dry Gangrene in a Child.

Dr. T. C. Wallace, of Cambridge, N. Y., adds to the report in the *Medical Record*, July 5, of a case of dry gangrene in a boy, two and a half years old, by Dr. Kelley, of Winchester, Ind., another in a girl, twenty months old. The child had been quite sick for several days with measles, 'under the care of an intelligent practitioner, and was fairly convalescent. Early in the morning of April 12, 1886, after a comfort-

able night, her right leg, up to and including the ankle, was found to be very cold. She lay in a crib-bed and it was thought she had protruded her foot between the slats from under the bed-clothes. The leg was wrapped in a warm flannel and replaced in bed, and no more thought of the matter until, after a few hours, it was examined and found to be still cold. More energetic means of warming the limb were resorted to—friction, hot water in bottles, etc.—but all of no avail. The child did not seem in any way worse, made no manifestation of pain, and appeared to suffer no discomfort. It was simply impossible to warm that foot, although every effort was made all the day and the succeeding night. During next day the foot assumed a livid hue, which gradually deepened in color. The next morning the limb was of death-like coldness up to and above the ankle, of a mottled mahogany color, darker at the toes and gradually growing lighter toward the ankle, where was a well-defined edge, indicating, I thought, the future line of demarcation. The next morning the big toe and the one next to it were in a state of gangrene, and a large gangrened spot was seen under the heel. The dark color near the front of the foot was more profound. The color above and around the ankle was much more natural and the parts warmer, in fact of normal warmth. The embolus had either been forced further down in the artery, or the collateral circulation had become more established. It was then hoped that, except for the gangrened spot under the heel, the heel itself might be saved by either Syme's or Pirogoff's amputation. In a few days all the toes underwent gangrene—true senile gangrene, dry, black and odorless. This gradually spread until the whole foot nearly to the tarsus was in a like condition.

The progress of the case was slow, the circulation about the ankle gradually becoming more active. After two or three demarcation lines were plainly indicated the true line at last formed, just anterior to the tarso-metatarsal joints, and on June 26 Dr. Wallace amputated through those joints. Happily the gangrene under the heel included only the soft parts, and the periosteum was not involved. The stump healed satisfactorily, but very slowly. The child's physical condition was good throughout the whole progress of the case, and she put on a large amount of flesh. She has enjoyed uninterrupted health ever since.

Doubtless, owing to the original embolism, the limb has never grown equally with its fellow. Its temperature is perfectly normal, but its contour is not so well developed, nor does it grow in length so fast. It is now seven-eighths of an inch the shortest.

On inquiry by letter Dr. Wallace learned that neither Dr. Frank H. Hamilton nor Dr. D. Hayes Agnew had ever seen spontaneous gangrene in a young child. He searched every authority he could get access to; and, aside from a general statement that such cases are occasionally recorded in children under ten years, he could find but two cases recorded: one in an infant aged eleven months after an attack of measles, and one in a child, whose age is not given, just recovering from measles. It is certainly singular that these two cases, as well as his own, should not only have had the measles but all three be convalescing therefrom. Dr. Nickerson, of Meriden, Conn., gave Dr. Wallace the history of a child two and one-third years old, attacked by a severe remittent fever, accompanied, on the third day, by smoky urine which proved to be half blood. When the fever had ceased, the urine was fast clearing up, and the child was sitting up in bed playing. Dr. Nickerson found the toes on one foot quite black and in dry gangrene. This rapidly extended up the leg and thigh, and before the child died the entire limb, to the junction of the trunk, was perfectly black.

Dr. Nickerson and Professor A. L. Loomis were both of the opinion that the three cases just mentioned were primarily cases of ulcerative endocarditis.

Aborting Gonorrhœa.

The Paris correspondent of the *Medical Press and Circular*, June 18, 1890, says, that M. Malécot has devised and recommended the following method for aborting an acute attack of gonorrhœa. After making the patient micturate, and washing his urethra out with a weak boric-acid solution, he injects an ordinary syringe of a solution of nitrate of silver (1:50), and on the following days of 1:100, or even 1:150. The solution is allowed to remain two or three minutes in the urethra. At the same time that the injections are being used, he prescribes frequent injections of some antiseptic solution. He prefers five centigrams of salicylate of mercury in one hundred

grams of water at a temperature of 30° to 40° C. (86°–104° Fahr.). A cotton plug impregnated with the antiseptic should be kept fixed in front of the meatus urinarius so as to absorb the pus as it escapes; and the plug should be changed as soon as it is soiled. From six to eight capsules of oil of sandal-wood are also prescribed for a dose.

As the result of this treatment, the author states that he has often obtained, in from three to four days, the cessation of an attack of gonorrhœa even when there was a profuse flow of pus.

Posthumous Labor.

A correspondent writes in the *Lancet*, July 19, 1890, that at Moglia, in the province of Mantua, there recently occurred a case of *post-mortem* delivery in some respects unique. A woman, Lavinia Merli by name, subject to chronic epilepsy, had suddenly lapsed into the cataleptic state when in the eighth month of pregnancy. So death-like was the trance that she was certified as dead and ordered to be buried. The coffin containing the unfortunate woman was closed and deposited in the mortuary chapel pending the grave-digger's work, when next morning it was found with the lid raised. The woman's body, now a corpse, was horribly contracted, and, closely pressed between the knees, lay a new-born child, quite dead. The grave-digger and his men, for reasons of their own, kept their discovery a secret and buried the two corpses. The facts, however, leaked out, and the judicial authorities, aided by physicians from Mantua, at once proceeded to exhume the coffin and examine its contents. A very minute and prolonged inspection was made, with the result that the physicians declared themselves satisfied that the mother was already dead when the child was expelled from the womb. From the position of the bodies and the commencing decomposition in which they were found, taken in connection with other considerations set out at length in the official report, the conclusion was arrived at that the gases, disengaged by the putrefactive process, and seeking an exit, had forced out the fetus; that, in short, the case was one undoubtedly very rare, but by no means unprecedented, in obstetric experience of "posthumous labor."

The incident, however, has attracted notice beyond the Mantuan province, and

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medico-legal discussion on its details is yet far from being exhausted. It is asked, not unnaturally, if the woman Merli had really ceased to live, how the coffin lid came to be even partially raised? She is not by any means the only patient, in catalepsy or "nona," who in quite recent Italian experience has been certified as dead and treated accordingly; and the anti-cremationists, making the most of such cases, are warning the public how still more slender, in apparent death, would be the chances of escape for Merli and her like, if, instead of the coffin, she had been consigned to the crematorium.

Medical Matters in Constantinople.

The city of Constantinople has always been a tempting field for the illegal practice of medicine, although there exists a code of regulations which, if faithfully executed, would greatly reduce the number of unqualified practitioners. Under the Supreme Board of Health an official list has been drawn up, containing the names of all legal practitioners, and the pharmacists are forbidden to dispense the prescriptions of any persons not named in that list. As a further precaution, the physicians are directed to write their prescriptions on an officially stamped form or paper, which is issued to them by the Imperial School of Medicine, and which should bear the printed name and address of the prescriber. According to the *Chemist and Druggist*, from which the foregoing has been abstracted, there is probably no town on earth where patent medicines are consumed to such an enormous extent as in Constantinople; the nostrums coming from France take the lead of all others, then follow English, Italian and German proprietary articles. Street vendors dispose of considerable quantities of quinine confections and pastilles of santonin, and in the bazaars a lively trade is done in drugs producing abortion, which are used to a large extent by the Turkish and Armenian women. The purchase of opium and hashish is almost unknown for private consumption, the trade being exclusively in the hands of wholesale merchants, and it may be observed that, whereas in the seventeenth and eighteenth centuries opium-smoking, in spite of strong prohibitive laws, was very common in Constantinople, very little of that is known to exist at the present time.

The Imperial School of Medicine has a strongly patriarchal character, and the tuition is almost entirely free. There are about three hundred students, the majority of whom are clothed and boarded at the expense of the government, but are bound, after the completion of their studies and examinations, to serve for a time in the army, either as pharmacists or as surgeons. The buildings now temporarily occupied by the medical school were formerly used as barracks, but they are beautifully situated in the centre of a park, under the direction of a division general. The anatomical collections are exceptionally fine, and the school might be described as well appointed and furnished, except for the neglect that is observed in the branch of chemistry, which appears to be the special care or concern of nobody. The chemical laboratory is hardly more than a nominal one, and nearly all the pharmaceutical students have to depend upon private resources for the prosecution of the practical part of their studies. The chemical department is under the direction of a brigadier general.—*New York Medical Journal*, August 23, 1890.

Treatment of Bubo.

Dr. L. Brocq, writing in the *Journal of Cutaneous and Genito-Urinary Diseases*, July, 1890, says that according to Dr. Cordier, of Lyon, the procedure which has given him the best results in the treatment of bubo is as follows: As soon as the cedema of the skin shows the presence of pus, he makes a puncture with a straight bistoury. There is discharged along with the blood some streaks of pus. No pressure is made, but the cavity is injected with about 15 drops of a solution of nitrate of silver (1 : 50). Without paying any attention to whether the solution flows out again or not, the wound and groin are dressed with iodoform and a spica bandage is applied. When this slight operation is done soon enough, Dr. Cordier says no purulent discharge follows, and the bubo disappears rapidly, leaving behind a sort of indurated nodule. When the puncture is made in a bubo much more advanced and in full suppuration, the pus must be carefully washed out. A first injection of the solution is made to cleanse the parts, and the second injection is left in. A decided inflammatory reaction is then established and free suppuration occurs, which

lasts for three or four days, and then becomes serous. Healing takes place rapidly, and the opening closes without leaving a cicatrix. Dr. Cordier has had the same results, whether the bubo was specific or simply inflammatory.

Board of Medical Examiners of New Jersey.

The State Board of Medical Examiners of New Jersey will meet in the Senate Chambers at the Capitol, in Trenton, on Thursday, October 9, at nine o'clock in the morning, for the purpose of examining candidates presenting themselves for a license to practice medicine in this State.

Under the present Medical Law of New Jersey, every person desiring to practice medicine or surgery as a resident in that State, who was not legally registered previous to July 4, 1890, must obtain a license from the Board of Medical Examiners.

Further information will be furnished by the Secretary, Dr. William Perry Watson, Jersey City, N. J.

Fluoroform.

The *Monthly Journal of Pharmacy* states that a French chemist, M. Meslans, has succeeded in preparing *fluoroform*. It is the analogue of chloroform and iodoform, the chlorine and iodine of these substances being replaced by fluorine in *fluoroform*. But whereas chloroform is a liquid and iodoform is a solid at ordinary temperatures, *fluoroform* is a gas. It is colorless, and has a pleasant ethereal smell, recalling that of chloroform.

Zinc Sulphite as an Antiseptic.

Dr. F. T. Houston read a paper at the last meeting of the British Medical Association, "On a Non-poisonous, Non-irritative Antiseptic Dressing." Calling attention to the poisonous and irritating nature of many of our ordinary antiseptic dressings, he spoke highly of the value of zinc sulphite as a non-poisonous and non-irritative dressing. It was used in the form of an impregnated gauze; this was tinted red with a vegetable dye. By this means it could at once be seen whether the zinc sulphite had undergone any decomposition, for on wet-

ting it the color disappeared if the sulphite had undergone no deteriorating changes.

Camphor a Solvent for Iodoform.

Camphor increases the solubility of iodoform in alcohol and ether. While one hundred parts of alcohol ordinarily dissolve not more than one and one-fourth parts of iodoform, the same amount of a saturated solution of camphor is capable of taking up as much as ten parts.

NEWS.

—Dr. George Strawbridge has resigned the Chair of Otology in the University of Pennsylvania.

—The newspapers announced on September 21, that a girl thirteen years old had given birth to triplets in Cincinnati.

—Dr. R. Curtis Gray has removed from 590 Atlantic ave., Brooklyn, to 652 Carroll street. His telephone number is "177 South."

—Dr. T. J. Whitten, of Nokomis, Ill., has purchased the David Prince Sanitarium at Jacksonville, Ill., and will take charge November 1, 1890.

—Dr. James A. Lydston, late chief of Eye and Ear Department, Pension Bureau, Washington, D. C., has been elected to the Chair of Chemistry of the Chicago College of Physicians and Surgeons.

—Dr. Joseph H. Coover died of heart failure September 25, 1890, at his residence in Harrisburg, Pa. He was in apparent good health up to the night before but was stricken during the night and died almost instantly.

—From Pittsburgh, it was reported, September 18, that a leper had been discovered and caused great alarm. The man's name is Nafsky, and he is supposed to be the same man who filled the inhabitants of a town in Ohio with terror.

—The *Philadelphia Inquirer*, September 22, reporting the return of Dr. Wm. H. Pancoast from Berlin, says that while there he had received much gratifying personal attention, and that he "spoke gratefully of some special compliments, the nature of which he modestly refused to reveal, though he owned that they were as flattering as they were unexpected."